EXHIBIT C

Precision Billing LLC • 80 West Madison Avenue • Dumont, NJ 07628 • (201)501-8500

Date: 07-23-	2010
HORIZON	
PO BOX 199	
NEWARK, NJ	07101
Patient	
DOP	
ID:	
Practice: IN-BA	LANCE HEALTH , LLC
Treating Provider:	RICK O. LAMBERT, MD
Enclosed you will f	ind claim forms that are being resubmitted as an appeal for processing.
These claims are n	ot duplicate. The enclosed are:
	corrected claims
	being refilled to correct an error in processing.
<u>×</u>	sent with progress notes to establish medical necessity.
	Other
Thank you for your	prompt attention.
Sincerely,	
Celle Langschultz	
illing Specialist	

7010 1670 0000 1631 0816

620209.001123



Date: 07-23-2010	
Practice: IN-BALANCE HEALTH LLC	•
Tax ld: 26-3205753	
Plan Administrator: HOY120N Plan Sponsor: EMPLOYER Address: PO BOX 199 Address: NEUXIVK, NJ 07101	
Re: Request for Patient Name III	summary plan description
Dear Plan Administrator:	
Enclosed please find a Designation of Authorized Rewith the requirements of the employee retirement is enclosed an Assignment of benefits to assure that paying the desires of my patient.	ncome security act of 1974 (ERISA). I have also
The enclosed Designation of Authorized Representat	ive permits IN-BALANCE HEALTH
***	o my patient under ERISA law. Those rights include:
Receiving notice regarding inquiries with r post service	espect to the determination of claims both pre and

• Receiving a description and copies of documents of all claims procedures (including any

procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as

620209.001128 preauthorization procedures or utilization review procedures) and the applicable time frames as set forth in the summary plan description.

- Obtaining a copy of the summary plan description
- Pursuing appeals of plan adverse decisions, to take legal action in any forum, including the courts, and to obtain all information from the plan that the claimant is entitled in order to pursue appeals:
- Taking all action permitted under applicable statutes and rules as authorized representative of my patient.

Accordingly, please provide this office with a copy of the summary plan description. Thank you for your compliance with the legal requirements. Please fax the summary plan description to 201-501-8523 or mail a copy to Precision Billing, LLC, Attn: Kelly J. Langschultz, 80 West Madison Avenue, Dumont, NJ 07628.

Sincerely

Kelly J. Laukschultz

Billing Supervisor

1500 toless this claim is within 30 days, we w	dil file a formal 🕏	22099 HORIZON BOSSNU LEG BOR 820 COLL L 2 8 NEWARK NU 07101
APPROVED BY NATIONAL CAPACITY ESTABLISHED ON CO.	w. as nemas	
1. MEDICARE MEDICAID TRICARE CHAMPUS (Medicare e) (Medicaet e) (Sponsor's SSN) (Medicaet	HEALTH PLAN BLKLING	ER Is INSURED'S LD NUMBER (For Program in Liaim 1)
2 PATIENTS NAME (Last Name, First Name, Middle Initial)	3. PATIENTS BIRTH DATE SEX	4 INSURED'S NAME (Last Name, First Name, Middle Imput)
6 PATIENTS ADDRESS (No. Street)	6 PAT:ENT RELATIONSHIP TO INSURED Soil Spouse Chief Other	7. INSURED'S ADDRESS [No., Street]
- STATE	a PATIENT STATUS Single Married Other	CTY TE
ZIP CODE TELEPHONE (Include Area Code)	Full-Time Part-Time	ZIP CODE TELEPHONE (Include Area Code)
I. OTHER INSUREY'S NAME (Lasi Name, Frst Name, Middle Intel)	Employed Student Student 10 IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S POLICY OR GROUP NUMBER	a, EMPLOYMENT? (Current of Previous)	a INSURED'S DATE OF BIRTH SEX
OTHER INSURED S DATE OF BIRTH SEX	b AUTO ACCIDENT? PLACE (State	M F
EMPLOYER'S NAME OR SCHOOL NAME	L OTHER ACCIDENT?	6 INSURANCE PLAN NAME OR PROGRAM NAME
INCLIDANCE IN AN MANE OF DOOMS AND MANE.	YES X NO	22099 HORIZON BOBSNU
Insurance Plan Name or Program Name	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO if year return to and complete item 9 and.
SIGNATURE ON FILE SIGNED DATE OF CURRENT MM DD WY ALLNESS (First symbosm) OR NJURY (Apprison) OR PREGNANCY (LMP) 15. IF GI GI	03/30/10 DATE	I FROM TO I
NAME OF REFERPING PROVIDER OR OTHER SOURCE	G NR 1891739421	18. MOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DO YY
RESERVED FOR LOCAL USE RICK O. LAMBERT MD		20. OUTSIDE LAST & CHARGES
DIAGNOSIS OR NATURE OF ELINESS OR INJURY (Relate flams 1, 2, 3 or 26 O 3, 7	or 4 to hem 24E by Line)	22. MEDICAID RESUBMISSION ORIGINAL REF NO.
26 10	M47 1	23. PRIOR AUTHORIZATION NUMBER
From To PUCEOF Explain	JRES, SERVICES, OR SUPPLIES Unusual Circumstances) MODIFIER POINTER	
30 10 03 30 10 24 23700	62 50 : 1234	1400 00 1 1891739421····
30 10 ,03 30 10 24 22505	62 1234	2200 00 1 NP 1891739421
31 10 ,03 31 10 24 23700	62 50 1 234	1400 00 1 NP 1891739421
31 10 03 31 10 24 22505	62 1 234	2200 00 1 NP 1891739421
01 10 04 01 10 24 23700	62 50 1234	1400 00 1 NP 1891739421
01 10 04 01 10 24 22505	[62 1 234	2200 00 1 NP 1891739421
EDERAL TAX I D NUMBER SSN EIN 26 PATIENT'S ACC		28 TOTAL CHARGE 29 AMOUNT PAID 30. BALANCE DUE
	YES NO	\$ 10800.00 \$ \$10800.00 33. BILLING PROVIDER INFO & PH & (201)3918282 RICK O LAMBERT MD
CLUDING DEGREES OR CREDENTIALS Sorbly that the sustements on the revenue for to this bill and are made a part thereof; 6 CHESTINUT	RGICAL CENTER RIDGE ROAD	, 10 SHIELD DRIVE
O. LAMBERT MD MONIVALE NO		WOODCLIFF LAKE NJ 07677
04/13/10		1891739421 b

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any porson who knowingly likes a statement of elem containing any misrepresentation or any false. Incomplete or misiazeding information may be guilty of a criminal act pursuinable under last and may be subject to civil penalties.

ASFERS TO GOVERNIZET PROGRAMS ONLY

ASPERS TO GOVERNIZERT PROGRAMS ONLY

ASPECARE AND CHARTPUS HAYTACING. If you required has the processor of any other processor of the processo

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount ourd by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and niagnosis coding systems

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)
I contributed the services shown on this form were modically indicated and necessary for the nealth of the patient and were personally lurin shed by me or violation. Then incident to my professional service by in yemployor, ander my immediate personal suprivision, except as otherwise expressly permitted by Medicard or CHAMPUS regulations.

For services to be considered as "uncident" to a physician in processional service, it) they must be randered under the physician a terminate personal superior by harhor employee, 2) they must be an interval field to approve an enterprise and 4) the services of monthly sicians to a included on the physician's personal service.

For CHAMPUS clams, I further certify that I (or it ly employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung clams, I further certify that the services performed viero for a Black Lung-related osurder

No Part B Medicare benefits may be paid unless this form is rendwood as required by disting taw and regulations (42 CFR 424 32).

NOTICE. Any one who misrepresents or faisities estential information to receive payment from Federal funds requested by this form may upon conviction be subject. to line and imprisonment under applicable Federal laws

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA. AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

Who are confirmed by CMS Criatiffus and OWCP in this year for information administration of the Medicare CHAMPUS FECA and BYTE 1 programs. Authority to collect information is in section 205(z) 1662-1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(z) and 424 5(a) 1872 and 48 USC 3101.41 CFR 101 of seq and 10 USC 1073 and 1086, 3 USC 8101 of seq, and 30 USC 901 of seq; 38 USC 813; EIO 9397

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you recoved are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carners, informedianes, medical review boards, health plans, and other organizations or Federal agencies, for the otherwise administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, if may be necessary to disclose information about the benefits you have used to a hospital or disclosing disclosures. are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: Sen the house modifying system No. 03-70-0501, titled, "Carner Medicare Claims Record," published in the Federal Reuster, Vol. 35 No 177, page 37349, Wed Sent. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," <u>Federal Register</u> Vol. 55 No. 40, Wed Feb. 28, 1990, Sed ESA 5, ESA-6, ESA-12, ESA-13, or as updated and regulated

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S). To evaluate cripibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and detainment on that the services supplies received are numbered by law

ROUTINE USE(S) information from claims and related documents may be given to the Dept. of Veterans Alfairs, the Dept. of Health and Human Services and or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA: to the Dept. of Justice for representations for the Services and consumer reporting agencies in connection with recoupling the Services and to Continue Information to information and the request of the person to whom a record pertains. Appropriate discretization of other legens: static local foreign government eyer is as, private custiness entities, and individual providers of care, or matters relating to entitlement, chains and individual providers of care, or matters relating to entitlement, chains and individual providers of care, or matters relating to entitlement, chains and individual providers of care, or matters relating to entitlement, chains and individual providers of care, or matters relating to entitlement, chains and individual providers of care, or matters relating to entitlement, chains and individual providers of care, or matters relating to entitlement, chains and individual providers of care, or matters relating to entitlement, chains and individual providers of care, or matters relating to entitlement, chains and individual providers of care, or matters relating to entitlement, chains and individual providers of care, or matters relating to entitlement, chains and individual providers of care, or matters relating to entitlement, chains and individual providers of care, or matters relating to entitlement.

DISCLOSUBES. Voluniary however, failure to provide information wit result in delay in payment or may result in denial of claim. With the one exception below, there are no ponalt is under these programs for information. However, failure to furnish information regarding the medical services renerred or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would on ay payment of the claim. Failure to provide more call information under if ECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section if 1289 of the Shoiat Security Act and 31 USC 3801. 3812 provide penaltios for withholding this it formation

You should be arrang that P.L. 100-503, the "Computer Maroung and Privacy Profession Act of 1988", pormute the government to verify information by way of computer marches

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extant of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments diamed for providing such services at the State Agency or Dept. of Health and Human Services may request

I further agree to accept, as payment in (iii), the amount paid by the Monticald program for those claims submitted for payment under that program, with the exception of sufficient deductible, consumance, co-payment or samilar cost-sharing charge.

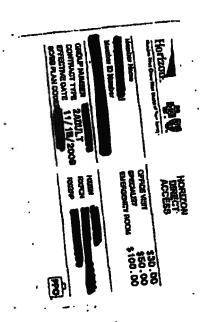
SIGNATURE OF PHYSICIAN (OR SUPPLIER): Confully that the services listed above were medically indicated and necessary to the health of this patient and were personally lumished by me or my employed under my personal direction

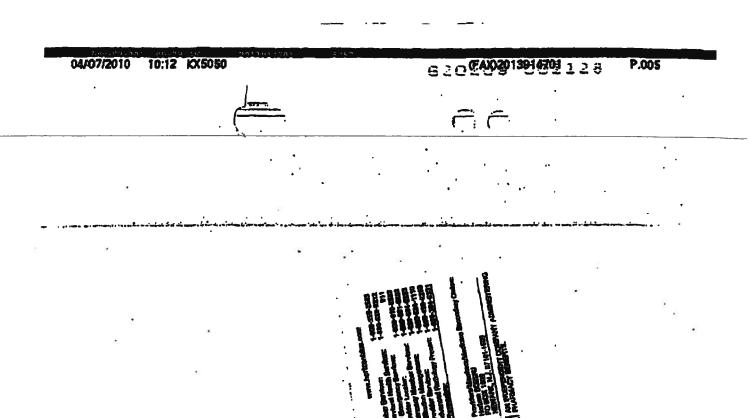
NOTICE Ph.s is to carrify that the foregoing information as "rue accurate and complete. Lunderstand that payment and satisfaction of this claim will be from Federal and State lunds, and that any false claims, statements, or documents, or concearment of a material fact, may be prosecuted under applicable Enderal or State evins.

Accounts to the Paperson's Reduction Act of 1.104, no princip are in guilled to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information objection is 0938-0910. The time incurrent to complete this information collection is estimated to average 10 minutes are response including time incurrent incurrent incurrent analysis of the information objection if you have any committee or unless incurrent i

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04/07/2010 10:12 KX5050

P.006

3/24/2010

Doctor: Or. Dr Philip C. Agrica

یت رسیان در بیند در براند سی میانید. : Mailing List,Code می

Home Phone Nbr:

Date Of Birth: 4 Genden -

SSNbr. Type Of Patient: 5 - Standard Group Health / Single or Co_inst

Balance Dua: \$3,530.00

Date Of Accident Or Iliness: Date First Consulted: 1/21/2010

Date Of Last Bill:

Date Of Same Or Similar Illness:

Amount of Last BIN:

Tot Disability Began: Tot Disability Ended:

Date Of Last Payment: 3/3/2010 Paid Since Last Billed: \$320.00

Work Phone:

Cell Phone:

Part Disability Began: Part Disability Ended:

Pald This Year: \$320.00 Nor Visits Since X-Ray:

Date Of Very First Visit: 1/21/2010

Status: Active

Date Of Very Last Visit: 3/3/2010

Date Of Last X-Ray: Total Nor Of Visits This Year: 12

Nor Of Other Referred This YR: Total Nor of Others Referred:

DIAGNOSIS:

.....INSURANCE.....

DOB: d

HORIZON BCBS OF NJ (PRIMARY) 87

PO BOX 820

NEWARK, NJ 07101-0820

Phone:

Fax:

--- insured's information -

Name: ◀

Address:

City ST ZIP: Grp / Pol Nbr:

EmpVSCH: ID#: 6

Relation: SELF

EffectiveDate: 11/15/2009

Expiration Date:

Authorization:

Co-Pay Amount: \$30 Co_Pay %: 3000J Doductable: \$2,500.00

Pald: Used: 2

Visits Allowed: 30 Amt Allowed:

Used: \$0.00

04/07/2010 10:13 KX\$050	620 FAX 2013914791128 P.008
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	W. THE TT C
	Health LLC Ridge Road
Möntvale	NJ-07645
Rick Lan	abert MD
Patient Cons	ultation Note
Date of service	ent Name
Social Security # DOB	Ins. ID Number
Chief Co	omplaint
1. B Shoulder @ 3/10 at	
after a day of "norm	d use" (is) Computer, list
1. Sting (no over head	1,54 mg).
2. Q shoulen @ 1/10 >	10/10 - 9.0.m is more
restricted than B.	
3, Neck O Wio - as	gravated by B should
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	7
9 (P) between shoulder bla	dio. 6-8/10

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M P.I	L- L-SC 7-1-08		-
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	Dr. Phil Poller MD P for MUA C-SE T-SC	c, B Shoulders	•
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04/07/2010	10:14 KX5050	*) / 6 -	S 2 9 (FA)) 2013914	01128 P.011
III. Revies	of Systems: other than the sy	MUA consultation co	3.72.	70
with regard	to recent bealth:			
HEENT:	(-) her	adaches (-) visua	problems (-) sore throat
Cardiovascula	r: (-) ohest pain	(-) claudication (-)) palpitations	
Pulmonary:	(-) cough	(-) dyspnea	(-) ankle edema	,
GI: (-) abdo	minal pain (-) n/v	(-) diarrhea	(-) constipation	(-) bleeding
3U: (-) dysur _	ia (-) hematuria	e .		
Veuro: (-) localized weakness	(-) memory loss	(-) numbn	255
fusculoskeletai: 	(+) joint pain	(f) stiffness read / shoulder / 9	(-) joint sw - - / : پیما لیسلاست	
sychiatric:	(+) emotional stress	(+) depression	(4) anxiety	(†-insomnia
Z. Past Medical diabetes	History: (-) HTN (-) asthma رنيست (+)	***	plesterolemia (-)	heart discuse
argical Eistory: سیبال	(+) prior surgeries	c su Comment	G, room	Láx x 3

Dama 3

04/07/2010 10:14 KX5050	1013814201 15 En	32 JFAN2013914701 1 2 8 P.01
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	MUA consultatio	3 -25- 10
		3-23-70
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•	Some	
	- Olig Landon	
VI. Allergies	- NEOA	
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VII. Family History	(-) diabetes (-) HTN	(-) heart dx (-) cancer
	e	
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VIII. Psycho-Social/	History	
Work Status	Employed Disabled Temporar	y Permanent Partial Total
Jub Description:	Operature luga	- Atomy
Marital Status	Single Warried Divorced Sept	arated Widowed
Children d	One 1 2 3 4 5	
Smoking History	on-smoker Half pack	Full pack Two packs
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Drug use No	one Other	
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	20136417/01 31/57	उ≟ 0-03	13914Z01 . OU1128	p
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		3-2	5-10	•
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vn.) (999	130/84 HR 70		اک	
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<i>∪</i> , , , , , , , , , , , , , , , , , ,	- Coll	,,,		
HEENT: (-) conjun	nctival pallor (-) scleral icte	irus (-) pharynge	al erythems	
Neck: (-) thyromeg	aly (-) bruits (-) lymph	adenopathy ((-) other masses	
Neck: (-) thyromeg	aly (-) pruits (-) tympn	eadenopathy ((-) other masses	
Neck: (-) thyromeg Heart: (-) murmur			(-) other masses	
	WPL		(-) other masses	
Heart: (-) murmur Chest: (-) rales	د) irregularity (-) gallop		(-) other masses	
Heart: (-) murmur Chest: (-) rales	(-) irregularity (-) gallop		(-) other masses	
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04/07/2010 10:15 1	C(\$0\$0	32769	52	FAX291391	1791;128	P.014
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Myofasci	al Trigger Points	;				
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	•					
.9.	Subscepular Thomboids -		in seem	s para	Jacob Co.	_
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	exion <u>40/90</u> I					
Extension	<i>35 /7</i> 0 I	Left Side Flex	20 /45	_Left Rotati	ion <u>29</u> /90	<u>)</u>
Range of M	lotion of the Tho	racic Spine: C)bserved b	out not meas	ured	
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(%	right was	left WNL	right	(Ten)		ieft + ~

Dermatomes; WNL=normal (+)= hyper sensitive (-)=hypo sensitive Myotomes; 5= normal, 4= mild weakness, 3=significant weakness, 2=can not resist more than gravity, 0= no sign of contraction Deep Tendon Reflexes; 2= normal, 3= hyper reflex, 1= diminished reflex, 0=absent

WNL

right 5

left

left

left

right

right

left

left

right were

right WNC

7:7

C:8

consultation con't	3.25-10	
	3.25-10	•
	3-25-10	
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Carvical Distraction (D) (2) (5.6-7		
Cervical Compression (A) (B) (C)		
valuativa s Sign		
Postural Analysis		
Head Tilt (19).		
Shoulder height (i)		
Winged Scapula Q- elevated E	medicly desisted	
Iliac Crest Height M.		-
Thoracic Kyphosis N/A		·
Thoracic Scoliosis N/7:		
Lumbar Lordosis Nr		
Lumbar Scoliosis W/A		·
Comment/ Note		

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•	consul	tation con't
	-	3-25-10
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Observation	ı:	•
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Ī5	right war left war	right s left 5	right +7 left +2	П
SI	right was left was	right 5 left 5	right 42 left 42	

Dernatomes; WNL=normal (+)= hyper sensitive (-)=hypo sensitive Myotomes; 5= normal, 4= mild weakness, 3=significant weakness, 2=can not resist more than gravity, 0= no sign of contraction

Deep Tendon Reflexes; 2= normal, 3= hyper reflex, 1= diminished reflex, 0=absent

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- Committee and the committee of the com	<u></u>	
Consultation con't	3-25-10	
Range of Motion of the Hips	مدانسيان بشكارة وارمو وتقالت بالمصورة الأو ويها ورموسة والموسية بالموا	
Right Hip		
Flexion 120/120 Abduction 50/50 Extension 10/15 External rotation 60/60	Adduction 30 /30 Internal Rotation 40	
Left Hip		
Flexion 120/120 Abduction 50/50 Extension 10/15 External rotation 60/60	Adduction 30 /30 Internal Rotation 42 /40	
Orthopedic Tests		
Straight Leg Raising		
Right Leg Painful arc at:		
0-35 degrees = slack in sciatic arbori	ization; no dural movement	
35-70 degrees = Probable joint pain Bilateral straight leg raising painful	= sacroiliac pathology	
70-90 degrees = sciatic root tension	over intervertebral disc	
Contra-lateral SLR (-)	g felois .	
Dorsiflexion of foot (-)		
Left Leg Painful arc at: DPchis		
0-35 degrees = slack in sciatic arbor	ization; no dural movement	
35-70 degrees = Probable joint pain Bilateral straight leg raising painful	= sacroiliac pathology	
70-90 degrees = = sciatic root tensio	n over intervertebral disc	
Contra-lateral SLR (-)		
Description of fact ()		

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Valsalva's Sign for nerve re	oot irritation Disens Present	س، و فسرت
Gapping. Test for sprain/stra (-) RT (-) LT	rain of the anterior sacroiliac ligament .	
Approximation Test for spr posterior sacroiliac ligament	rain/strain of the sacroiliac joint and/or the (-) RT (-) LT	
Iliac Compression Test indi (-) RT (-) LT	icating posterior sacroiliac ligament sprain	
Sacroiliac Rocking Test (-)	RT (-)LT for posterior sacroiliac joint	
(-)	RT (-) LT for Iliopsoas pathology	
	elvic instability and muscle weakness - Does not eccorate	
Gaenslen Test for SI joint parirritation. (-)RT (-) LT	thology, hip pathology and L4 nerve root	
	WNL	
	contracture of adduction muscles confirmed contracture of abduction muscles confirmed	
Thomas Test for hip flexion of	contraction (-) RT (-) LT	
Rectus Femoris Contracture	e; Ely's Test (-)RT (-) LT	
Ober's Test for contracture of	f tensor fasciae latae (-) RT (-) LT	
Hamstring Contracture Test	t (-)RT (-)LT	
Patrick's Test for hip patholog	gy (-) RT (-) LT	
Patrick's Test for Iliopsoas co	ontracture (-) RT (-) LT	

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Examination	of the Knee	1 13.52[] ``
Observation:	L1T.	_
Palpation:		-
	h	_
	7	
Range of Motion of the Knees		•
Right Knee		
Flexion /135 Extension	<u>/15</u> ! Rotation/40	
Left Knee		
Flexion /135 Extension	/15	
The second secon	l Rotation/40	
Valgus Stress Test for medial instability	of the knee: (-) RT (-) LT	
Varus Stress Test for lateral instability o	of the knee: (-) RT (-) LT	
Lachman's Test for instability of the ant	erior cruciate ligament	
Drawer Test for instability of the posterio	or cruciate ligament; (-) RT (-) LT	
McMurray's Test for medial meniscus p	athology (-) RT (-) LT	
McMurray's Test for lateral meniscus pa	athology (-) RT (-) LT	
Apley's Test (-) RT (-) LT		

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	constitution con	't
		3-25-10
ر. بالمنافق من المنافق ال	Examination of the	Shoulders
Observation		•
Palpation	Supraspinstus (D. S. Bic. Tendo	Assequen's Otherbusts
Range of motion	n of the Shoulders Right	Left
Forward Flexion: ac	etive <u>140</u> /180 Passive <u>/50</u> /18	0 active 1/0/180 Passive 150/180
Extension: a	ctive 30/60 Passive 40/60	0 active <u>20</u> /60 Passive <u>30</u> /60
Abduction: a	ctive 140/180 Passive 150/11	80 active 120 180 Passive 150 1800
Adduction: a	ctive <u>60</u> / 75 Passive <u>65</u> /7	5 active 60 / 25 Passive 65 / 185
Internal Rotation: ac	tive 35/60 Passive 40/90	active 30 / 60 Passive 35 / 60
External Rotation: ac	ctive 35 /60 Passive 49 /90	active <u>33</u> / 60 Passive <u>\$6</u> / 60
Orthopedic Tests	·	
Yergason's Test	for bicipital tendonitis:	(-) RT (ALT)
Drop-Arm Test f	or rotator cuff pathology	(-) RT (PLT)
Supraspinatus Te	st .	(FRT (FLT)
Impingement Sig	n.	(FRT) (-) LT

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1. (Shoulder Adhesive Capsulit	3	736.0
2. @ Shoulder		***
3. BICIPITAL TENDONITIS (DShouble	\	726.10
4. CONTRACTUME (B) SHOULPER REGIO		718.4
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6. CERVICAL TORKICOLIS & DISCOC	•	847.0
7. Thorneis semm/steam Plan		744.0 847./
PATIBAT HAS SUFFICIENT MORE THAN 4	YEARS & RECUEENAS	
FREEN SHOULDER JO TO APHEEIVE	CAPLUTY & GIMMON	L .
SHE HAS FOILED SHOULDER SURGERY	·	
HER SHOVLOEF FOUR TION 19 Comfe		
ADD IS MANIFULATION WHOLL ANEST		
HER (B) SHOWLDERS HECK & UPPER	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	
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Rick Lambert MD	Date 3.25-10	_

ick Lambert, MD M.U.A Specialist

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P.022

Montvale

Surgical Center

6 Chestnut Ridge Road Montvale NJ 07645.... Tel (201) 391-4700

OPERATIVE REPORT Davl of 3

Patient Name: Date: March 30, 2010 Facility for Procedure: MSC

Primary Surgeon: Rick Lambert, MD Assisting Surgeon: Phillip Agrice, DC Anesthesia: Michael Reuvini, MD

- Procedure Performed: 1. Manipulation Under Anesthesia of the right shoulder
 - 2. Manipulation Under Anesthesia of the left shoulder
 - 3. Manipulation Under Anesthesia of the cervical spine
 - 4. Manipulation Under Anesthesia of the thoracic spine

adhesive capsulitis, right shoulder Pre-operative Diagnosis: 1. 726.0

726.10 rotator cuff syndrame

718.41 contracture shoulder region .

2. 726.0 adhesive capsulitis, right shoulder

726.10 rotator cuff syndrome

718.41 contracture shoulder region

3. 847.0 torticollis

> 722.0 cervical discopathy

4. 847.1 thoracic sprain/strain

7291 myalgia/myospasm

Post-operative Diagnosis: Same: See progress report for work up

Procedure in Detail

Patient was prepared in a pre-operative area with an IV line established for the administration of anesthesia. Having already been supine on a gurney, patient was wheeled into the operating room. Patient was then prepared for monitoring by the anesthesiologist and OR nurse. MAC was induced and the patient was sufficiently sedated to start our procedure.

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P.023

Manipulation of the cervical spine; MUA of the cervical spine was performed for torticollis as well as a nexus to the shoulder region. It was performed sequentially prior to the shoulder to allow maximum release of the muscles associated with both neck and shoulder region. We used the standard approach for MUA of the cervical spine as follows:

The patient was stabilized in the supine position by the assisting doctor. Mild caudal to cephalad traction and passive stretching, laterally and obliquely were done by the primary doctor to break up adhesions and increase range of motion in the cervical spine. The assisting doctor was stabilizing the patient while this procedure was being done. A cervical manipulation was done at C1-C7 spinal levels and cavitations were elicited.

Manipulation of the Shoulder, right: The patient was maintained in the supine position. Patient's arm was extended and supported by the primary doctor while the shoulder was passively placed though all ranges of motion noting for limitations and barriers formed by adhesions formed by the rotator cuff. Circumduction of the glenohumereal was performed clockwise then counterclockwise, breaking down labrum adhesions. Next, the shoulder was elevated was flexed to 90 degrees while one hand stabilized the AC joint and the other hand continued to flex the shoulder to maximum range of motion. A steady gradual increase of pressure was applied in flexion breaking down adhesions and allowing the shoulder to reach approximately 140 degrees. Returning the shoulder to approximately 90 degrees of flexion, the shoulder was then gently distracted with one hand while the other hand was contacted over the anterior portion of the glenohumcral joint. An A-P force was thrust gently through the shoulder achieving cavitation. The patient was then turned on his, allowing access to the posterior aspects of the rotator cuff. Extension and internal rotation of the shoulder allowed normal physiological winging of the scapula, giving access to the rhomboid muscles. Grasping the winged scapula, and protracting it broke down adhesions and allowed maximum stretching of the rhomboid muscles and levator scapulae. While still in the lateral position, the shoulder joint was passively put through all ranges of motion noting mild restrictions persisting at approximately 160 degrees of forward flexion. Also noted, were mild restrictions of movement in shoulder extension and internal rotation

Manipulation of the Shoulder, left: The patient was maintained in the supine position. Parient's arm was extended and supported by the primary doctor while the shoulder was passively placed though all ranges of motion noting for limitations and barriers formed by adhesions formed by the rotator cuff. Circumduction of the glenohumereal was performed clockwise then counterclockwise, breaking down labrum adhesions. Next, the shoulder was elevated was flexed to 90 degrees while one hand stabilized the AC joint and the other hand continued to flex the shoulder to maximum range of motion. A steady gradual increase of pressure was applied in flexion breaking down adhesions and allowing the shoulder to reach approximately 150 degrees. Returning the shoulder to approximately 90 degrees of flexion, the shoulder was then gently distracted with one hand while the other hand was contacted over the anterior portion of the glenohumeral joint. An A-P force was thrust gently through the shoulder achieving cavitation. The patient was then turned on his, allowing access to the posterior aspects of the rotator cuff. Extension and internal rotation of the shoulder allowed normal physiological winging of

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P.024

the scapula, giving access to the rhomboid muscles. Grasping the winged scapula, and protracting it broke down adhesions and allowed maximum stretching of the rhomboid muscles and levator scapulae. While still in the lateral position, the shoulder joint was passively put through all ranges of mulion noting mild restrictions persisting at approximately 170 degrees of forward flexion. Also noted, were mild restrictions of movement in shoulder extension and internal rotation

Manipulation of the thoracic spine: Patient was maintained in the supine position on the operating table. The patient's right arm was grasped by the primary physician, while the primary placed his other hand beneath the patient n the lower, posterior region of the thoracic spine on the right side. While the assisting doctor tractioned the patient's pelvis in a caudal direction causing a passive stretching of the thoracic musculature. This procedure was then repeated on the patient's left side. She was then rolled laterally by the assisting doctor. The primary doctor's cupped fist was placed posterior to the thoracic region. The patient was then placed supine, by the assisting doctor, on the cupped fist of the primary doctor. A mild A-P force was applied and cavitations were elicited. The cupped fist was then moved cephalad along the spinal area applying additional manipulations to the region.

The MUA procedure was concluded at that point. Patient tolerated procedure very well and without incident. At the conclusion of the procedure, the patient was returned to the recovery room where proper monitoring equipment was utilized and was discharged in satisfactory condition as reported in the progress notes.

Post-Operative Care Day One:

The patient was advised to spend the remainder of the day relaxing and avoiding any work or exertion. There were no restrictions on diet. Patient was further advised to resume regular regimen of medication prescribed prior to the procedure. Because the patient is returning tomorrow, there will be no eating or drinking after ten p.m this evening.

Rick bambert, M.D

Certified: Manipulation Under Anesthesia

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P.025

Montvale

Surgical Center

.8-Chestnut.Ridge-Road-Montvale-NJ-07645---------Tel (201) 391-4700

OPERATIVE REPORT Day 2 of 3

Patient Name:

Date: March 31, 2010

Facility for Procedure: MSC

Primary Surgeon: Rick Lambert, MD Assisting Surgeon: Philip Agrics, DC Anesthesia: Carles Frias, MD

- Procedure Performed: 1. Manipulation Under Anesthesia of the right shoulder
 - 2. Manipulation Under Anesthesia of the left shoulder
 - 3. Manipulation Under Anesthesia of the cervical spine
 - 4. Manipulation Under Anesthesia of the thoracic spine

Pre-operative Diagnosis: 1. 726.0 adhesive capsulitis, right shoulder

726.10 rotator cuff syndrome

718.41 contracture shoulder region

2. 726.0 adhesive capsulitis, right shoulder

726.10 rotator cuff syndrome

718.41 contracture shoulder region

3. 847.0 torticollis

cervical discopathy 722.0

4. 847.1 thoracic sprain/strain

myalgla/myospasm 7291

Post-operative Diagnosis: Same: See progress report for work up

Procedure in Detail

Patient was prepared in a pre-operative area with an IV line established for the administration of anesthesia. Having already been supine on a gurney, patient was wheeled into the operating room. Patient was then prepared for monitoring by the anesthesiologist and OR nurse. MAC was induced and the patient was sufficiently sedated to start our procedure.

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P.026

Manipulation of the cervical spine; MUA of the cervical spine was performed for torticollis as well as a nexus to the shoulder region. It was performed sequentially prior to the shoulder to allow maximum release of the muscles associated with both neck and shoulder region. We used the standard approach for MUA of the cervical spine as follows:

The patient was stabilized in the supine position by the assisting doctor. Mild caudal to cephalad traction and passive stretching, laterally and obliquely were done by the primary doctor to break up adhesions and increase range of motion in the cervical spine. The assisting doctor was stabilizing the patient while this procedure was being done. A cervical manipulation was done at C1-C7 spinal levels and cavitations were elicited.

Manipulation of the Shoulder, right: The patient was maintained in the supine position. Patient's arm was extended and supported by the primary doctor while the shoulder was passively placed though all ranges of motion noting for limitations and barriers formed by adhesions formed by the rotator cuff. Circumduction of the glenohumereal was performed clockwise then counterclockwise, breaking down labrum adhesions. Next, the shoulder was elevated was flexed to 90 degrees while one hand stabilized the AC joint and the other hand continued to flex the shoulder to maximum range of motion. A steady gradual increase of pressure was applied in flexion breaking down adhesions and allowing the shoulder to reach approximately 160 degrees. Returning the shoulder to approximately 90 degrees of flexion, the shoulder was then gently distracted with one hand while the other hand was contacted over the anterior portion of the glenohumeral joint. An A-P force was thrust gently through the shoulder achieving cavitation. The patient was then turned on his, allowing access to the posterior aspects of the rotator cuff. Extension and internal rotation of the shoulder allowed normal physiological winging of the scapula, giving access to the rhomboid muscles. Grasping the winged scapula, and protracting it broke down adhesions and allowed maximum stretching of the rhomboid muscles and levator scapulae. While still in the lateral position, the shoulder joint was passively put through all ranges of motion noting mild restrictions persisting at approximately 175 degrees of forward flexion. Also noted, were mild restrictions of movement in shoulder extension and internal rotation

Manipulation of the Shoulder, left: The patient was maintained in the supine position. Patient's arm was extended and supported by the primary doctor while the shoulder was passively placed though all ranges of motion noting for limitations and barriers formed by adhesions formed by the rotator cuff. Circumduction of the glenohumereal was performed clockwise then counterclockwise, breaking down labrum adhesions. Next, the shoulder was elevated was flexed to 90 degrees while one hand stabilized the AC joint and the other hand continued to flex the shoulder to maximum range of motion. A steady gradual increase of pressure was applied in flexion breaking down adhesions and allowing the shoulder to reach approximately 165 degrees. Returning the shoulder to approximately 90 degrees of flexion, the shoulder was then gently distracted with one hand while the other hand was contacted over the anterior portion of the glenohumeral joint. An A-P force was thrust gently through the shoulder achieving cavitation. The patient was then turned on his, allowing access to the posterior aspects of the rotator cuff. Extension and internal rotation of the shoulder allowed normal physiological winging of

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P.027

the scapula, giving access to the rhomboid muscles. Grasping the winged scapula, and protracting it broke down adhesions and allowed maximum stretching of the rhomboid muscles and levator scapulae. While still in the lateral position, the shoulder joint was passively put through all ranges of motion noting mild restrictions persisting at approximately 180 degrees of forward flexion. Also noted, were mild restrictions of movement in shoulder extension and internal rotation

Manipulation of the thoracic spine: Patient was maintained in the supine position on the operating table. The patient's right arm was grasped by the primary physician, while the primary placed his other hand beneath the patient n the lower, posterior region of the thoracic spine on the right side. While the assisting doctor tractioned the patient's pelvis in a caudal direction causing a passive stretching of the thoracic musculature. This procedure was then repeated on the patient's left side. She was then rolled laterally by the assisting doctor. The primary doctor's cupped fist was placed posterior to the thoracic region. The patient was then placed supine, by the assisting doctor, on the cupped fist of the primary doctor. A mild A-P force was applied and cavitations were elicited. The cupped fist was then moved cephalad along the spinal area applying additional manipulations to the region.

The MUA procedure was concluded at that point. Patient tolerated procedure very well and without incident. At the conclusion of the procedure, the patient was returned to the recovery room where proper monitoring equipment was utilized and was discharged in satisfactory condition as reported in the progress notes.

Post-Operative Care Day Two:

The patient was advised to spend the remainder of the day relaxing and avoiding any work or exertion. There were no restrictions on diet. Patient was further advised to resume regular regimen of medication prescribed prior to the procedure. Because the patient is returning tomorrow, there will be no eating or drinking after ten p.m this evening.

Rick Lambert, M.D

Certified: Manipulation Under Anesthesia

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P.028

<u>Montvale</u>

Surgical Center

--6-Chestnut-Ridge-Road-Montvale-NJ;-07645---Tel (201) 391-4700

OPERATIVE REPORT Day3 of 3

Patient Name

Date: April 1, 2010

Facility for Procedure: MSC

Primary Surgeon: Rick Lambert, MD Assisting Surgeon: Philip Agrics, DC Anesthesis: Michael Reuvini, MD

Procedure Performed: 1. Manipulation Under Anesthesia of the right shoulder

2. Manipulation Under Anesthesia of the left shoulder

3. Manipulation Under Anesthesia of the cervical spine 4. Manipulation Under Anesthesia of the thoracic spine

Pre-operative Diagnosis: 1. 726.0 adhesive capsulitis, right shoulder

726.10 rotator cuff syndrome

718.41 contracture shoulder region

2. 726.0 adhesive cansulitis, right shoulder

726.10 rotator cuff syndrome

718.41 contracture shoulder region

3. 847.0 torticollis

722.0 cervical discopathy

4. 847.1 thorscic sprain/strain

7291 myalgia/myospasm

Post-operative Diagnosis: Same: See progress report for work up

Procedure in Detail

Patient was prepared in a pre-operative area with an IV line established for the administration of anesthesia. Having already been supine on a gurney, patient was wheeled into the operating room. Patient was then prepared for monitoring by the anesthesiologist and OR nurse. MAC was induced and the patient was sufficiently sedated to start our procedure.

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P.029

Manipulation of the cervical spine; MUA of the cervical spine was performed for torticollis as well as a nexus to the shoulder region. It was performed sequentially prior to the shoulder to allow maximum release of the muscles associated with both neck and shoulder region. We used the standard approach for MUA of the cervical spine as follows;

The patient was stabilized in the supine position by the assisting doctor. Mild caudal to cephalad traction and passive stretching, laterally and obliquely were done by the primary doctor to break up adhesions and increase range of motion in the cervical spine. The assisting doctor was stabilizing the patient while this procedure was being done. A cervical manipulation was done at C1-C7 spinal levels and cavitations were elicited.

Manipulation of the Shoulder, right: The patient was maintained in the supine position. Patient's arm was extended and supported by the primary doctor while the shoulder was passively placed though all ranges of motion noting for limitations and barriers formed by adhesions formed by the rotator cuff. Circumduction of the glenohumereal was performed clockwise then counterclockwise, breaking down labrum adhesions. Next, the shoulder was elevated was flexed to 90 degrees while one hand stabilized the AC joint and the other hand continued to flex the shoulder to maximum range of motion. A steady gradual increase of pressure was applied in flexion breaking down adhesions and allowing the shoulder to reach approximately 175 degrees. Returning the shoulder to approximately 90 degrees of flexion, the shoulder was then gently distracted with one hand while the other hand was contacted over the anterior portion of the glenohumeral joint. An A-P force was thrust gently through the shoulder achieving cavitation. The patient was then turned on his, allowing access to the posterior aspects of the rotator cuff. Extension and internal rotation of the shoulder allowed normal physiological winging of the scapula, giving access to the rhomboid muscles. Grasping the winged scapula, and protracting it broke down adhesions and allowed maximum stretching of the rhomboid muscles and levator scapulae. While still in the lateral position, the shoulder joint was passively put through all ranges of motion noting mild restrictions persisting at approximately 180 degrees of forward flexion. Also noted, were mild restrictions of movement in shoulder extension and internal rotation

Manipulation of the Shoulder, left: The patient was maintained in the supine position. Patient's arm was extended and supported by the primary doctor while the shoulder was passively placed though all ranges of motion noting for limitations and barriers formed by adhesions formed by the rotator cuff. Circumduction of the glenohumereal was performed clockwise then counterclockwise, breaking down labrum adhesions. Next, the shoulder was elevated was flexed to 90 degrees while one hand stabilized the AC joint and the other hand continued to flex the shoulder to maximum range of motion. A steady gradual increase of pressure was applied in flexion breaking down adhesions and allowing the shoulder to reach approximately 175 degrees. Returning the shoulder to approximately 90 degrees of flexion, the shoulder was then gently distracted with one hand while the other hand was contacted over the anterior portion of the glenohumeral joint. An A-P force was thrust gently through the shoulder achieving cavitation. The patient was then turned on his, allowing access to the posterior aspects of the rotator cuff. Extension and internal rotation of the shoulder allowed normal physiological winging of

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P.030

the scapula, giving access to the rhomboid muscles. Grasping the winged scapula, and protracting it broke down adhesions and allowed maximum stretching of the rhomboid muscles and levator scapulae. While still in the lateral position; the shoulder joint was passively put through all ranges of motion noting mild restrictions persisting at approximately 180 degrees of forward flexion. Also noted, were mild restrictions of movement in shoulder extension and internal rotation

Manipulation of the thoracic spine: Patient was maintained in the supine position on the operating table. The patient's right arm was grasped by the primary physician, while the primary placed his other hand beneath the patient n the lower, posterior region of the thoracic spine on the right side. While the assisting doctor tractioned the patient's pelvis in a caudal direction causing a passive stretching of the thoracic musculature. This procedure was then repeated on the patient's left side. She was then rolled laterally by the assisting doctor. The primary doctor's cupped fist was placed posterior to the thoracic region. The patient was then placed supine, by the assisting doctor, on the cupped fist of the primary doctor. A mild A-P force was applied and cavitations were elicited. The cupped fist was then moved cephalad along the spinal area applying additional manipulations to the region.

The MUA procedure was concluded at that point. Patient tolerated procedure very well and without incident. At the conclusion of the procedure, the patient was returned to the recovery room where proper monitoring equipment was utilized and was discharged in satisfactory condition as reported in the progress notes.

Post-Operative Care Day Three:

The patient was advised to spend the remainder of the day relaxing and avoiding any work or exertion. There were no restrictions on diet. Patient was further advised to resume regular regimen of medication prescribed prior to the procedure.

Rick Lambert, M.D.

Certified: Manipulation Under Anesthesia

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